LONG-TERM CARE OMBUDSMAN
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-FUNDED BY THE COMMISSION ON AGING-

ELDERLY MEDI-CAL PATIENTS AS SECOND CLASS CITIZENS

A STUDY OF DISCRIMINATORY ADMISSIONS PRACTICES IN SAN FRANCISCO NURSING HOMES

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A PROGRAM OF THE FAMILY SERVICE AGENCY OF SAN FRANCISCO

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EXECUTIVE SUMMARY

The purpose of this nine month study was to investigate whether San Francisco Skilled Nursing Facilities (SNFs) were being discriminatory by failing to admit Medi-Cal patients, especially those needing "heavy care". There have been many complaints regarding patients who are transferred out of county because a bed cannot be found here in San Francisco.

We found that twenty-nine percent (29%) of all Medi-Cal county residents who needed a long-term bed in an SNF were transferred out of the county. Eighty percent (80%) of those transferred needed "heavy care".

We believe that discriminatory practices exist because of economic incentives. The difference between the private rate and the Medi-Cal reimbursement rate is about $35 per day. There are no legal prohibitions to this practice. Therefore, it is less profitable for facilities to retain patients having some or all of their care paid for through Medi-Cal. San Francisco facilities are situated in a "seller's market" and are financially motivated to screen out new Medi-Cal admissions.

The San Francisco Ombudsman Program is unable to advocate for patients without a foundation of Federal, State, or local law. Such laws are essential if we are to stop discrimination against our poor, frail seniors.

The report recommends the following:

1. Legislate equal Medi-Cal and private pay rates to reduce preferential discrimination.

2. Legislate First Come - First Served admission policies.

3. Improve reimbursement rates for "heavy care" patients.

4. Increase the number of "heavy care" patients at Laguna Honda Hospital.

5. Develop a City-sponsored legislative program to prevent discrimination against poor elderly nursing home patients.

FOREWARD

The San Francisco Long Term Care Ombudsman Program is a program of Family Service Agency of San Francisco. The program operates under federal law (Older Americans' Act) and various state laws.

The California Department of Aging - Office of State Long Term Care Ombudsman is the state agency with responsibility for the program. Our local contract monitor is the San Francisco Commission on Aging, the local Area Agency on Aging for San Francisco.

Funds for this study were obtained as the result of the settlement of the lawsuit Johnson v. Rank. Local Ombudsman programs were awarded a percentage of the settlement payment for the purposes of advocating for Medi-Cal funded residents of nursing homes in California.

The Ombudsman Program chose to investigate a chronic complaint. That is: San Francisco nursing homes are reluctant to make beds available for new admissions of Medi-Cal funded patients. The results of the study follow.

For their help in producing this report we would like to thank the following people:

Debra Kaufman for her research and drafts; Diana Barich for her editing; the City's acute hospital discharge planners for their assistance in our data collection; the staff of the California Department of Health Services-Medi-Cal Field Office for making their office and statistics available to us; the San Francisco Commission on Aging for approving our request to undertake the project; and Harriet Prensky and San Mateo Legal Aid Society for their legal advocacy for Medi-Cal clients in California's nursing homes.

Positions expressed are not necessarily those of the California Department of Aging nor of the San Francisco Commission on Aging.

1.0 STATEMENT OF THE PROBLEM:

A shortage of needed Skilled Nursing Facility (SNF) beds for Medi-Cal recipients, especially for "heavy care" patients, exists in San Francisco. This study examines this problem, more specifically examining discrimination in admissions to SNFs for Medi-Cal recipients, and the effects of such discrimination, i.e. out-of-county placement. The report makes recommendations to reduce discriminatory practices on a statewide basis and reduce the number of San Francisco Medi-Cal patients being transferred out of county.

2.0 METHODOLOGY:

The Ombudsman office examined San Francisco Medi-Cal records to determine the number of out-of-county transfers of Medi-Cal recipients from S.F. acute care hospitals within the 9 month period from 9/86 to 5/87. Data was also obtained directly from the acute care discharge planners about out-of-county transfers from their acute care SNF. The Medi-Cal office does not track such data. One hundred percent of those Medi-Cal patients needing prolonged care (4 months or more) were examined. A survey of out-of-county SNFs who accept S.F. patients was conducted to determine the current placement of S.F. residents transferred. Medi-Cal admissions policies of

S.F. SNFs were checked through a phone survey, as was bed availability for Medi-Cal recipients in San Francisco. The 100% "sample" and the examination of "Exit" and "Entrance" data, give this study a high reliability.

3.0 RESULTS:

The data indicate that 29% (200 of 700) of all S.F. low income elders (Medi-Cal recipients) needing prolonged SNF care were transferred to SNFs in other counties in a 9 month period. Eighty percent (80%) of those transferred needed "heavy" or total care. (Graphs 1 and 2) In a survey of one-third of all those transferred, we found that very few ever return to S.F. During the 9 month study period, only 2 of 70 returned to S.F., one going to Laguna Honda Hospital and another to the Hebrew Home.

A severe shortage of available beds in San Francisco for Medi-Cal patients currently exists. (graph 3)

In a one day telephone survey, our researcher found that only one S.F. Medi-Cal certified SNF had any Medi-Cal beds available and even this one had only a few. Several S.F. Medi-Cal certified facilities simply were not taking any new Medi-Cal patients, preferring to wait to fill any empty beds with higher paying "private-pay" patients. Several facilities mentioned maintaining separate waiting lists - one for Medi-

Cal patients - which was usually fairly long, and one for "private-pay" patients - which was either short or non-existent. No specific laws prohibit this practice.

4.0 ANALYSIS OF RESULTS:

"A shortage (exists) in S.F. of availability of Skilled Nursing Facilities for patients with heavy care requirements and for persons eligible for Medi-Cal...A significant percent of S.F. residents continue to be placed in SNFs in other counties... Private skilled nursing facilities control admissions in such a way that 'heavy' care, and Medi-Cal patients do not become their preponderant case load. Under present levels of reimbursement, they favor patients able to pay private rates as well as those who do not have a heavy care requirement."

The above paragraph aptly describes the current crisis in S.F.'s long term care scene. Unfortunately, it was written seven years ago by Satten, Burstar, and O'Rourke (S/B/O) Association for the Department of Health of San Francisco. The situation, rather than having improved since 1981, has considerably worsened. In the past seven (7) years, 10 of 12 Medi-Cal certified facilities (of the 12 certified in 1980) have decreased the number of Medi-Cal patients they admit, by an average of 15%, concurrently with increasing demand for

Medi-Cal beds. The 1981 study by S/B/O demonstrated that 33% of those elders being transferred out-of-county needed heavy care. Today, 80% of those Medi-Cal recipients being transferred out-of-county are heavy care patients.

THE 1981 REPORT RECOMMENDED THAT LAGUNA HONDA HOSPITAL NOT INCREASE ITS PERCENTAGE OF LIGHT AND MODERATE CARE PATIENTS THEREBY INCREASING THEIR HEAVY CARE CAPACITY, ACCOMMODATING FOR THE EXPECTED GROWTH OF THIS GROUP. AT THAT TIME, ONE THIRD OF ALL PATIENTS WERE "HEAVY CARE".

Laguna Honda Hospital had just opened Clarendon Hall for light and moderate care patients.

The situation has been exacerbated by the advent of Medicare's prospective payment system whereby hospitals have a financial incentive to discharge patients as quickly as possible, augmenting the pressure on hospital discharge planners to find immediate placements in Long Term Care facilities. Now we are seeing more severely ill patients in Skilled facilities due largely to hospitals' financial incentives to discharge patients quickly. Although nursing home patients now require more care, statutes for minimum staffing and physician visitation have not increased significantly.

While the following practices of some of San Francisco's SNFs have not been declared illegal by a court, they are in effect discriminatory by serving as a barrier to admission for Medi-Cal recipients: 1. maintaining separate waiting lists for "private-pay" and Medi-Cal patients; 2. limiting

the number of Medi-Cal admits; 3. refusing to admit any new Medi-Cal patients; and 4. not admitting heavy care Medi-Cal patients when the facility has the capacity of providing for heavy care patients.

Actually proving that these practices exist can be difficult. While all facilities use written admission agreements, many facilities participating in discriminatory practices rely on oral or unwritten terms and conditions for admission, such as "private-pay" duration of stay contracts. These agreements are one form of discrimination which has been prohibited by the Health Care Financing Administration (HCFA), the Federal regulatory body. However, enforcement is weak, and some facilities disregard the prohibition. At least two S.F. SNFs verbally acknowledged that they will not accept a "private-pay" patient unless the prospective patient can stay at least one and a half or two years as privately-paying before going onto Medi-Cal. Most of the other practices discussed are verbally acknowledged and understood by hospital discharge planners. It is generally acknowledged among discharge planners that many Medi-Cal heavy care patients will have to be transferred out-of-county, because of the difficulty of finding a bed for them in San Francisco.

5.0 FACTORS CONTRIBUTING TO A SHORTAGE OF MEDI-CAL BEDS:

The major factors contributing to a shortage of Medi-Cal beds in S.F. are financial. San Franciscan elders in need of SNF care are in the unfortunate position of living in a city with more patients than there are beds. Since the demand exceeds the supply, S.F. facilities can be, and are selective in who they admit and to some extent, what kind of services they provide. The situation is likely to continue worsening as the demand continues to grow and the supply remains relatively stable. In The City and elsewhere in the state, if both a Medi-Cal patient and a "private-pay" patient want the single available bed, it will most likely go to the "private-pay" patient, yielding the nursing home a greater profit.

San Francisco's SNFs charge "private-pay" patients an average of 40% more than the Medi-Cal reimbursement rate. While it may be good business sense to sell to the highest bidder, it is nonetheless discriminatory, and defective public policy. This results in our poor and disabled elders having fewer options and often being uprooted from family and familiar surroundings.

6.0 TRACKING TRANSFERRED PATIENTS:

San Franciscans who become "out of county" patients generally do one or more of the following: 1. remain out of county; 2. die out of county; 3. return to the originating acute care hospital.

In a random survey of 64 of the 201 patients transferred out-of-county, only two had returned to San Francisco. According to the Director of Nurses for the leading Marin facility accepting S.F.Medi-Cal patients, they have one patient who has wanted to return to The City for the past year and a half but no one has been able to find him a placement. She said, "He feels like he's in outer Siberia and doesn't care where he goes as long as it is in San Francisco"

Many gerontologists feel that elders are adversely affected, physically and psychologically, by unrequested transfers. Certainly an out-of-county transfer makes it more difficult for family and friends, often elderly themselves, to visit. More and more it is felt that family and friends play an important role in greater quality of care in facilities. Families are now beginning to form family councils that suggest and recommend change in facilities. Families act as constant checks to facility staff that care is being provided. When long distance transfers occur, all of these family activities are disrupted. Transferring 30% of

our poor and disabled elders out-of-county is not acceptable.

7.0 RECOMMENDATIONS:

The issue of discrimination against Medi-Cal patients at admissions needs to be addressed in S.F. and in California. Ultimately, the state needs to enact cogent, enforceable legislation to ensure fair access to SNF care for our state's poor and disabled elders. The problem is not unique to San Francisco, but rife throughout the country. In the absence of clear Federal initiative in this area, several states have taken their own action through regulations and legislation to ameliorate the situation. Some of these remedies and others are discussed below.

7.1 RATE EQUALIZATION: INCREASE MEDI-CAL RATES/LOWER "PRIVATE-PAY" RATES

Facility operators argue that the reason they do not admit more Medi-Cal patients is because the Medi-Cal rate is too low to make it economically feasible. However, with the Medi-Cal census at 50% or more in at least 8 S.F. facilities,

empirical evidence shows that facilities can offer care at current rates that is acceptable to regulatory bodies. While the Medi-Cal rate may be too low for some facilities to meet costs, raising it, if it remained below the private-pay rate would not do much to discourage discrimination. Most SNFs concur that the driving force behind Medi-Cal discrimination is the disparity between Medi-Cal and "private-pay" rates, resulting in a situation where Medi-Cal recipients have very limited access to SNF care and "private-pay" patients quickly become impoverished due to higher rates designed to make-up the loss of revenue from Medi-Cal. However, if Medi-Cal rates were increased and "private-pay" rates decreased, thereby equalizing both rates, existing financial incentives to discriminate would disappear. Legislation ensuring rate equalization would require that the "private-pay" rate not go above the Medi-Cal rate. Minnesota has successfully implemented rate equalization. This type of legislation would go a long way toward preventing discrimination.

7.2 FIRST-COME, FIRST-SERVED POLICIES:

Connecticut has enacted legislation requiring Medicaid certified facilities to admit patients on a first come, first-served basis, regardless of their form of payment. Facilities maintain daily logs of requests for admissions.

Applicants are given dated receipts and the waiting list is made accessible to them. Massachusetts also uses a first-come, first served policy prohibiting separate waiting lists for "private-pay" and Medicaid recipients in Medicaid certified facilities. This type of legislation would be very useful in reducing certain types of Medi-Cal discrimination, although it would not address the root cause of the discrimination: differential reimbursement rates. It is unclear whether a county could, by local ordinance, require first-come, first-served admissions. Advocates in San Francisco will investigate the possibility of such an ordinance.

7.3 CHANGING REIMBURSEMENT PATTERNS:

Barriers to access for Medi-Cal patients are much greater for those with heavy care demands. As reported, 80% of those Medi-Cal recipients transferred out-of-county had heavy or total care needs. This occurs because of financial disincentives for the SNF to accept heavy care patients. Facilities are reimbursed at the same rate as for light care patients. Several states including West Virginia, Maryland, Ohio, Minnesota, New York, Illinois, and Colorado are in the process of developing differential reimbursement systems to provide financial incentives for SNFs to accept heavy care patients through a higher reimbursement rate. Michigan and

Florida have initiated a unique approach to differential reimbursement patterns whereby they pay a bonus to SNFs for accepting a certain percentage of Medicaid recipients.

As the Federal government continues with Medicare's Prospective Payment System we will see the demand for beds by sicker, heavier care patients rise at an accelerated rate the need to ensure equal access to SNF care for our sicker more disabled elderly will increase proportionally.

7.4 SHIFT LIGHT AND MODERATE PATIENT CARE BEDS AT LAGUNA HONDA HOSPITAL TO HEAVY CARE, AND STAFF THE 300 EMPTY BEDS:

The growing need for beds for heavier care patients is apparent. The recommendation made in 1981 to increase heavy care capacity and decrease light and moderate care beds at Laguna Honda Hospital remains a good and viable suggestion. Laguna Honda Hospital currently has over 300 empty unstaffed beds. These beds are desperately needed by San Francisco Medi-Cal patients, especially severely disabled elders. We propose that these beds be immediately be made available for heavy care patients who are now being needlessly transferred out-of-county. While this would only provide a short-term solution, it would nevertheless, ameliorate the situation in S.F. A 1987 Blue Ribbon Report recommended that the City

make 620 new beds available by 1990; seventy (70) of which should be added at Laguna Honda immediately. We would further recommend that as beds open up at Clarendon Hall, heavy care patients be admitted. We do not believe this will jeopardize the City's hopes for further development of a continuum of services to the elderly.

7.5 ENGAGE IN DISCUSSIONS BY ALL PARTIES INVOLVED:

Finally, discussion needs to be initiated regarding the best possible solution to reduce Medi-Cal discrimination in California, incorporating the needs and interests of all those involved. Advocates, providers, and policy-makers need to look at existing legislation enacted by other states as models. We need to design our own plan, taking into account the particular needs of San Francisco's and California's elderly. Ultimately, the elderly need strong state legislation to prohibit blatant Medi-Cal discrimination.

7.6 THE COMMISSION ON AGING SHOULD REQUEST THE SAN FRANCISCO LEGISLATIVE REPRESENTATIVES TO PROPOSE A PACKET OF CORRECTIVE LEGISLATION.

As a clearly unsatisfactory set of practices continues

statewide, San Franciscan seniors are especially hurt. The Commission on Aging should act in presenting this information to the county Health Commission (responsible for Laguna Honda) as well as the Board of Supervisors.

The City and County have not solved the problems identified in 1981 and need to devote attention and resources to doing so. It is expected that as the population of San Franciscans continues to age, the problem will only increase.

Although the City and County could alleviate the short-term problem of the shortage of beds, this will not solve the long-term problem.

There simply are not enough beds in San Francisco for those that need them (97% occupancy rate). San Francisco must find ways of encouraging or providing for more beds. An exploration of incentives to private industry is needed.

The City and County should request State Legislative leaders to address these concerns through state legislation.

7.7 REFERRALS MADE TO THE BUREAU OF MEDI-CAL FRAUD

During the time of our research and writing of this report, a significant piece of legislation was passed in California.

SB 526 (Mello) was signed into law by Governor Deukmejian in September, 1987. (Chapter 637/87) This law expands the functions of the Bureau of Medi-Cal Fraud within the

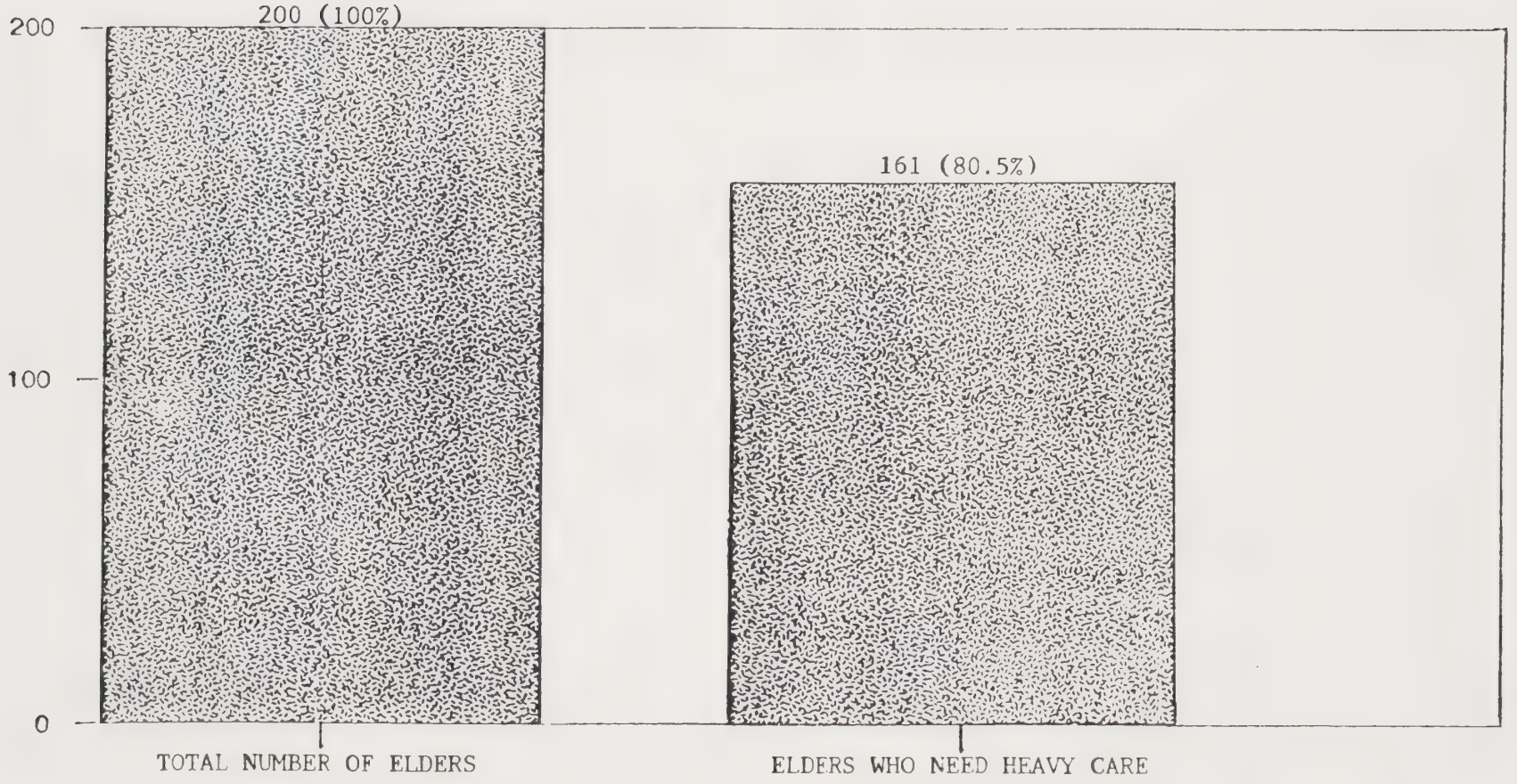
Office of Attorney General.

Specifically, this Bureau "reviews, investigates, and prosecutes complaints of abuse, neglect, and discriminatory treatment of patients in health care facilities which receive Medi-Cal payments". It is concerned with criminal rather than civil matters.

Although this Bureau has not traditionally investigated, monitored or prosecuted Medi-Cal providers for discriminatory practices, it certainly has the potential power to do so. Ombudsmen will begin referring complaints of discrimination upon admission to the Bureau as well as complaints of abuse and neglect.

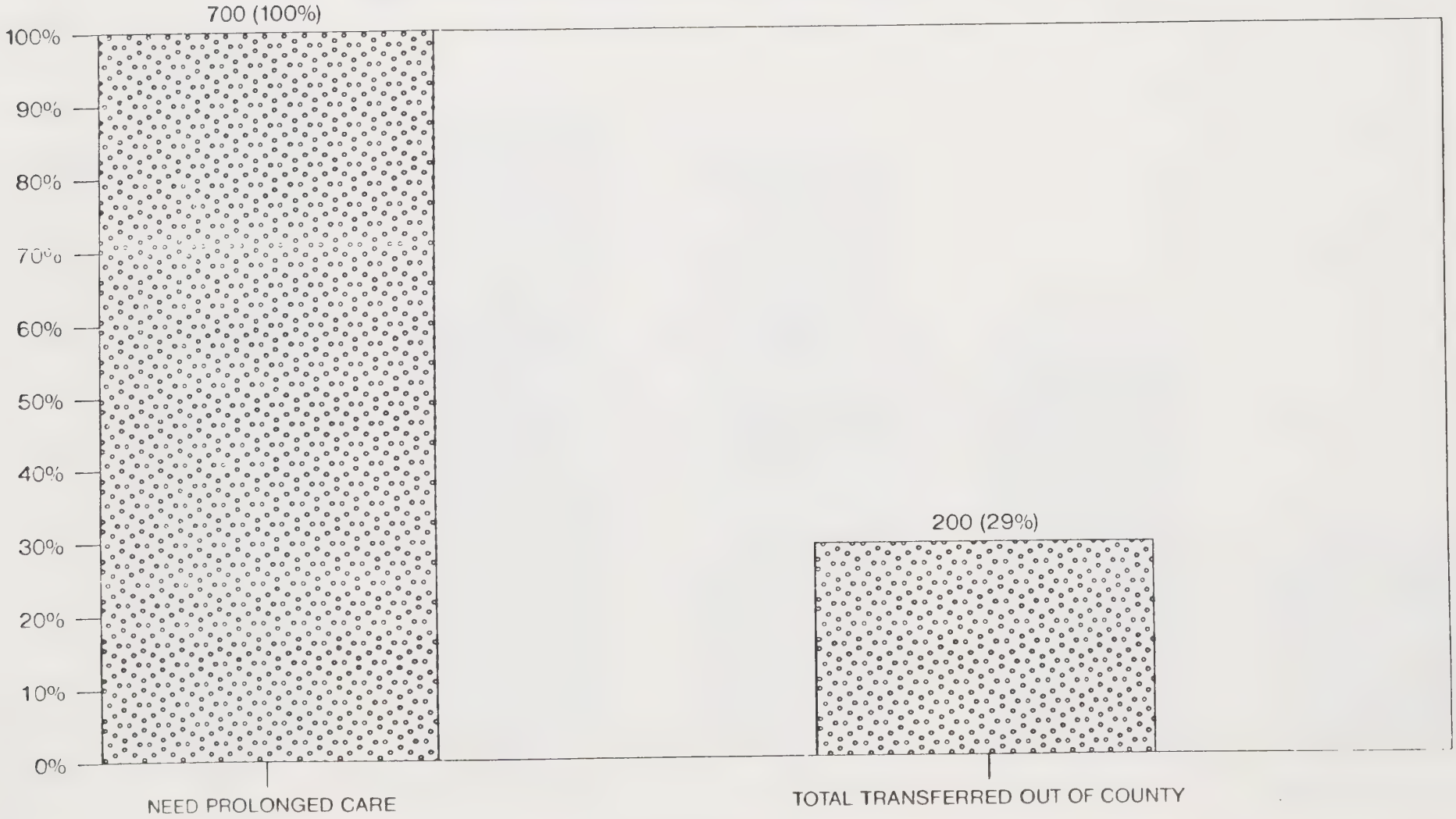
Those with specific complaints of discrimination of Medi-Cal patients should forward that information to this office or to the Ombudsman programs within other counties.

LOW INCOME ELDERS
TRANSFERRED OUT OF COUNTY



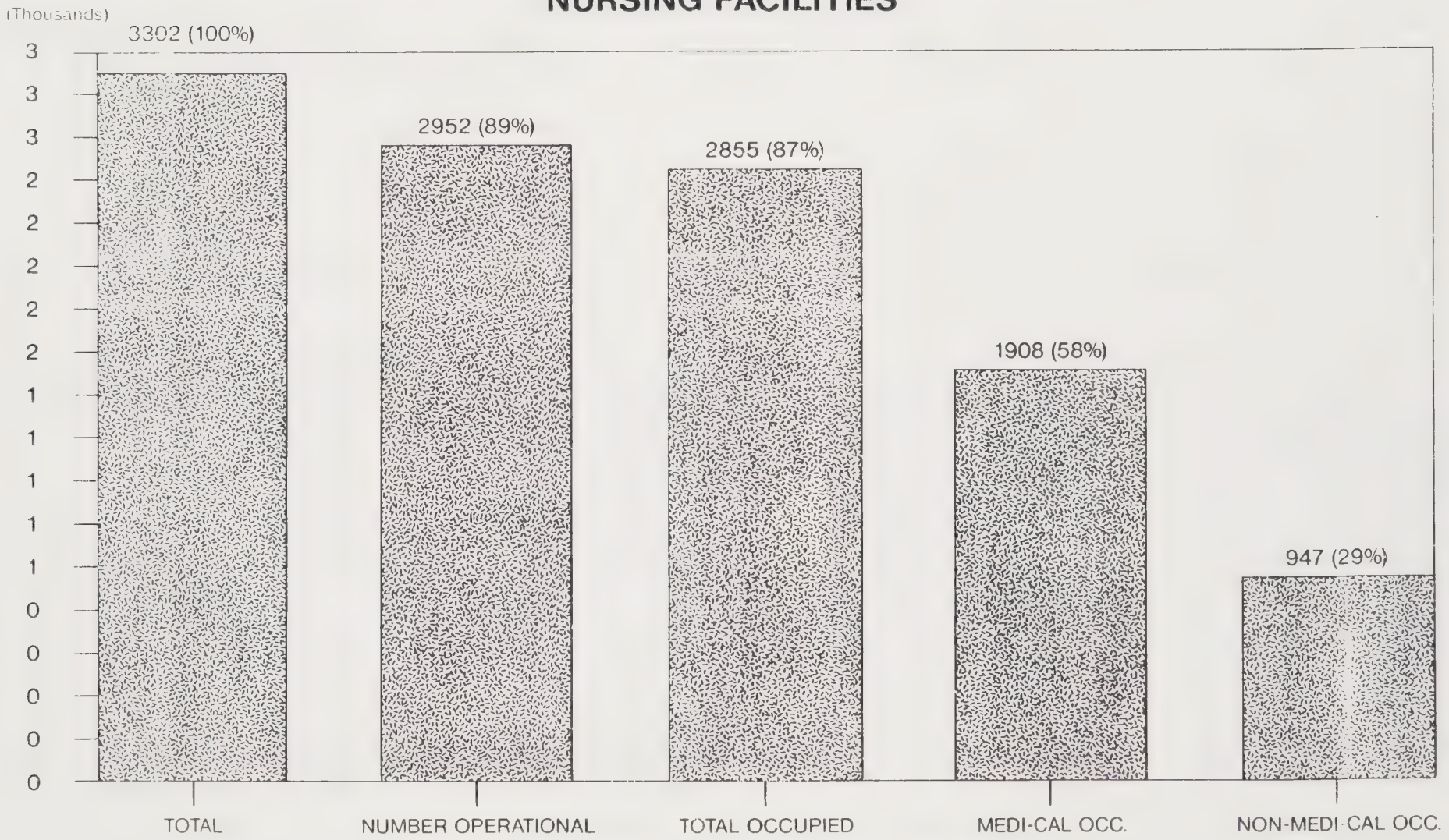
PERIOD STUDIED 9/86 - 5/87
NUMBER OF PATIENTS

LOW INCOME ELDERLY
WHO NEED PROLONGED LONG TERM CARE



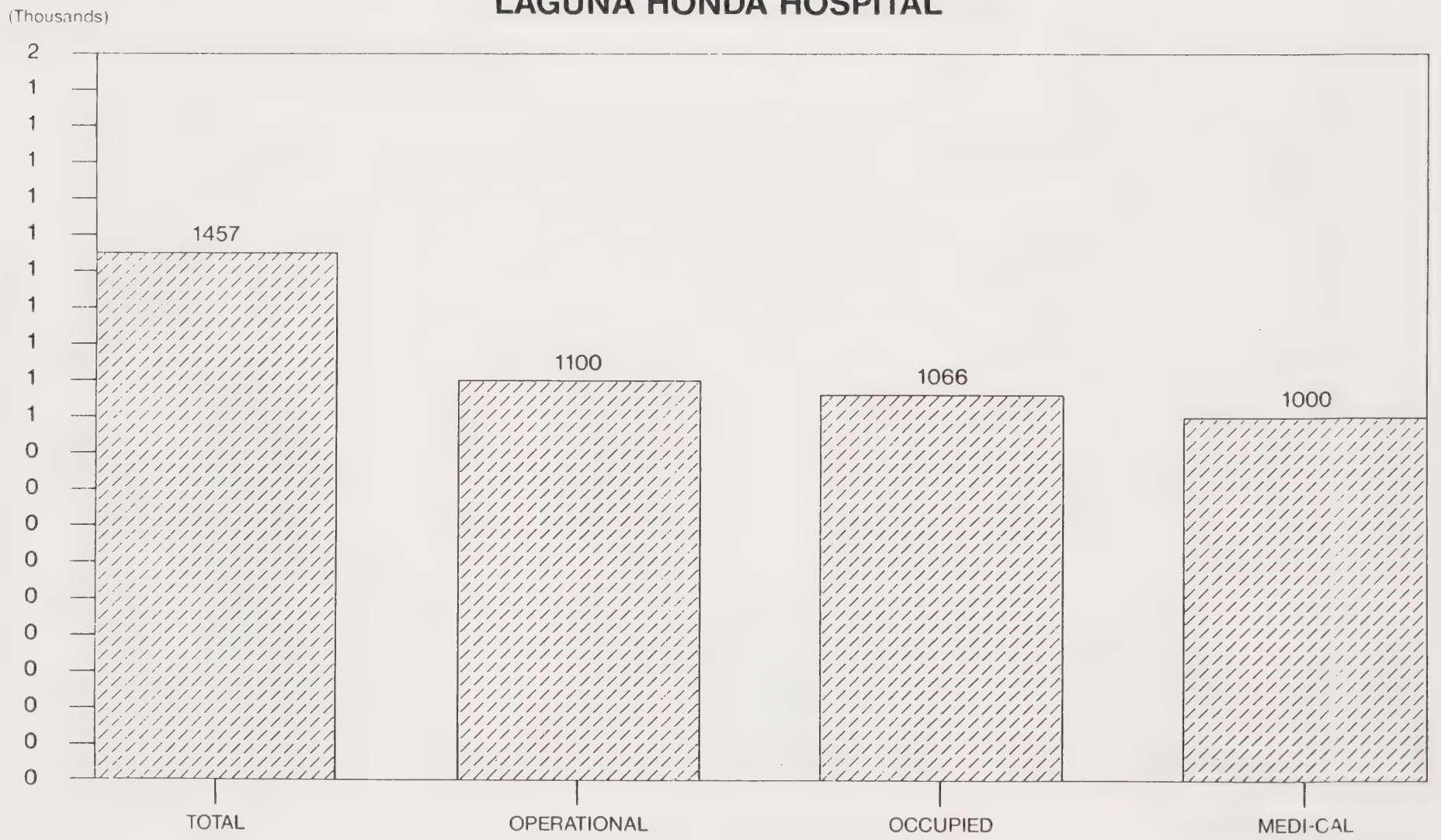
PERIOD STUDIED 9/86 – 5/87
NUMBER OF PATIENTS

OCCUPANCY RATES OF S.F. SKILLED
NURSING FACILITIES



1987
NUMBER OF BEDS

OCCUPANCY OF S.F. PUBLIC PROVIDER:
LAGUNA HONDA HOSPITAL



TOTAL BEDS

MEDI-CAL OCCUPANCY RATES OF THE THREE LARGEST NON-PUBLIC PROVIDERS